

Private Health Plans Under the ACA: In Brief

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Introduction

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended, expands federal private health insurance market requirements, and requires the creation of health insurance exchanges (marketplaces) to provide certain individuals and small employers access to private insurance, among other provisions. While some of ACA's private insurance provisions have already become effective, full implementation begins in 2014 and beyond. Given the breadth of ACA's reforms to the existing private insurance market and creation of new health insurance marketplaces, there is interest in understanding what types of health plans may be offered once these ACA provisions are fully implemented.

This report provides short descriptions of health plans¹ that may be offered inside and outside of exchanges, and includes information about interaction with other selected ACA provisions. The descriptions are displayed in a side-by-side format to facilitate comparison of exchange and non-exchange plans. This report does not attempt to identify all forms of health insurance coverage, but does address all plan types specified under ACA's exchange provisions, as well as major medical plans and certain limited benefit plans offered outside of exchanges. In addition, this report indicates the applicability of ACA's market reforms to plans offered in the private market.

Private Health Plans Available Inside and Outside of ACA Exchanges

ACA establishes health insurance exchanges (marketplaces)² where qualified individuals and small businesses can “shop” for private health insurance.³ Exchanges will offer several types of health plans. Exchange plans will provide a comprehensive set of covered benefits (i.e., the “essential health benefits”),⁴ except for stand-alone dental plans (which will have to meet a narrow set of benefit requirements). While most of these comprehensive plans will be available to any individual or employer who is qualified to enroll in an exchange, some plans will be available only to specific subpopulations (for example, child-only plans). Finally, some plans offered in exchanges may also be offered outside of exchanges.⁵

¹ It is commonplace within the insurance industry to refer to consumers using two different terms—policyholders (for nongroup coverage) and enrollees (for group coverage)—in order to distinguish the type of health coverage a given consumer has. For the sake of simplicity, this report will refer to consumers as enrollees, even if they have coverage through the nongroup market. Likewise, coverage will be referred to as a health plan, even if the coverage is provided through the nongroup market.

² For a comprehensive discussion about ACA exchanges, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*.

³ Before 2016, states will have the option to define “small employers” either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so).

⁴ ACA specifies 10 broad benefit categories which must be included in essential health benefits: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness and chronic disease management; and (10) pediatric services, including oral and vision care.

⁵ Plans that are offered both inside and outside of exchanges must charge the same premium. In addition, ACA allows the types of health plans that are currently offered in the private market to continue to be offered in 2014 and beyond,

Exchanges are not intended to be substitutes or replacements for the existing private health insurance market. Prior to ACA, private entities sold health plans to individuals, families, and groups (e.g., employers). This preexisting private market will continue after full implementation of ACA. Thus, ACA envisions the availability of private plans both inside of exchanges, and outside of them in the ongoing market. Moreover, ACA's private insurance requirements establish a federal floor with respect to health insurance regulation. Individual states will continue to regulate health insurers in their respective states, and may apply state-only insurance requirements, as long as such requirements do not prevent the application of ACA's market reforms.⁶ Depending on the specific state-only requirements, such reforms may apply to plans inside exchanges as well as outside.

Table 1 provides summaries of the following plan types: qualified health plans, child-only plans, multi-state plans, plans offered through health cooperatives, catastrophic and other high-deductible health plans, plans that provide limited benefits (such as dental-only and other types), plans offered through group and nongroup markets, grandfathered plans, self-funded plans, union plans, and retiree-only plans. The summaries denote whether such plans may be offered inside and/or outside of exchanges, and indicate if individuals enrolled in such plans may avail themselves of the premium tax credits and cost-sharing subsidies established under ACA,⁷ and whether enrollment in a given plan meets the requirements to comply with ACA's individual mandate.⁸ While each plan type is described in a separate row, these categories are not mutually exclusive. For example, a high-deductible health plan may be offered as a plan in the nongroup, small group, or large group market.⁹

as long as those other plan types comply with applicable federal and state law.

⁶ §1321(d) of ACA.

⁷ ACA provides two forms of financial assistance to certain individuals and families who enroll in exchange plans: tax credits to go toward the purchase of insurance and cost-sharing subsidies to go towards costs associated with use of covered services. For additional information about this financial assistance, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

⁸ ACA includes a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance. ACA specifies a broad range of sources of comprehensive coverage that will meet this requirement. In addition, the Secretary of Health and Human Services is authorized under ACA to recognize other coverage as meeting this requirement. For additional information about the individual mandate, see CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*.

⁹ The private health insurance market is often described as containing three segments: the nongroup (individual), small group, and large group markets. The term "nongroup" refers to health insurance coverage offered to individuals (and potentially their dependents) that is not in connection with a group health plan (which is sponsored by an employer or employee organization, such as a union).

Table 1. Private Health Plans Available Inside and Outside of ACA Exchanges

Types of Health Plans	Inside ACA Exchanges	Outside ACA Exchanges
Qualified Health Plans (QHPs)	QHPs will meet all applicable private market reforms and provide comprehensive coverage, such as covering the essential health benefits (EHBs). ^a Qualified individuals who are enrolled in QHPs through an individual exchange (not a SHOP exchange) ^b may be eligible to receive premium tax credits and cost-sharing subsidies. Individuals enrolled in QHPs will have complied with ACA's individual mandate.	QHPs purchased outside the exchanges must meet all the same requirements as exchange QHPs, but individuals enrolled in QHPs outside of exchanges are not eligible to receive premium tax credits or cost-sharing subsidies. Individuals enrolled in QHPs will have complied with ACA's individual mandate.
Child-only Plans	An insurance company that offers a QHP through an exchange must also offer a child-only plan at the same level of coverage (bronze, silver, gold, or platinum) ^c as that QHP. Exchange child-only plans are available to individuals who are less than 21 years of age. Qualified individuals who are enrolled in child-only plans through an exchange may be eligible for premium tax credits and cost-sharing subsidies. Individuals enrolled in child-only plans will have complied with ACA's individual mandate.	Child-only plans offered outside the exchanges are not required to limit the offer of such plans to individuals under age 21. Individuals enrolled in child-only plans outside the exchanges are not eligible to receive premium tax credits or cost-sharing subsidies. Individuals enrolled in child-only plans will have complied with ACA's individual mandate.
Multi-State Plans (MSPs)	MSPs are QHPs that will eventually be available through every exchange, so that individuals and small businesses will have access to these plans, regardless of where they live. Qualified individuals who are enrolled in an individual MSP may be eligible for premium tax credits and cost-sharing subsidies. Individuals enrolled in MSPs will have complied with ACA's individual mandate.	N/A

Types of Health Plans	Inside ACA Exchanges	Outside ACA Exchanges
Health Cooperatives	Health cooperatives who receive loans under the “CO-OP” program established under ACA, and are certified to participate in exchanges, must offer QHPs through individual exchanges (and may also offer plans through SHOP exchanges). CO-OPs must ensure that individual and small group QHPs account for at least 2/3 of their business. Qualified individuals who are enrolled in a CO-OP QHP through an individual exchange may be eligible for premium tax credits and cost-sharing subsidies. Individuals enrolled in CO-OP plans will have complied with ACA’s individual mandate.	The coverage offered by health cooperatives outside of exchanges will be substantially the same as the CO-OP coverage offered in exchanges. However, cooperatives that only operate outside of exchanges are not subject to the 2/3 rule. Individuals enrolled in cooperatives outside the exchanges are not eligible to receive premium tax credits or cost-sharing subsidies. Individuals enrolled in plans offered through cooperatives will have complied with ACA’s individual mandate.
Catastrophic and other High Deductible Health Plans (HDHPs)	<p>“Catastrophic” plans^d are available only to individuals under 30 years of age and those who have a hardship exemption from the individual mandate.^e These individual plans do not have to meet the actuarial value standards specified for QHPs, but they must include coverage for the EHBs. Premium tax credits and cost-sharing subsidies may not be used toward these plans. Individuals enrolled in catastrophic plans will have complied with ACA’s individual mandate.</p> <p>A high-deductible health plan that does <i>not</i> meet the specific criteria to be a catastrophic plan may be offered in the exchanges, as long as the HDHP meets the standards applicable to one of the various QHPs that may be offered through exchanges. As long as HDHPs meet all applicable exchange requirements, premium tax credits and cost-sharing subsidies may be used toward these plans. Individuals enrolled in high-deductible plans will have complied with ACA’s individual mandate.</p>	<p>Catastrophic plans offered outside the exchanges must comply with the same requirements that apply to catastrophic plans offered in the exchanges. Premium tax credits or cost-sharing subsidies may not be used toward catastrophic plans outside the exchanges. Individuals enrolled in catastrophic plans will have complied with ACA’s individual mandate.</p> <p>Other HDHPs may be offered outside of the exchanges, as long as they meet all applicable insurance standards. These HDHPs may be broadly offered to individuals and groups. Premium tax credits or cost-sharing subsidies may not be used toward HDHPs outside the exchanges. Individuals enrolled in high-deductible plans will have complied with ACA’s individual mandate.</p>
Stand-alone Dental Plans	Dental-only plans may be offered in exchanges, either as stand-alone plans or in conjunction with a QHP, as long as the dental plans include pediatric dental benefits. Premium tax credits and cost-sharing subsidies may not be used toward dental-only plans. Enrollment only in a stand-alone dental plan does not meet ACA’s individual mandate.	Dental-only plans may be offered outside the exchanges. Such plans are not required to offer pediatric dental benefits as included in EHBs. Premium tax credits and cost-sharing subsidies may not be used toward dental-only plans. Enrollment only in a stand-alone dental plan does not meet ACA’s individual mandate.

Types of Health Plans	Inside ACA Exchanges	Outside ACA Exchanges
Nongroup, Small Group, and Large Group Plans (non-ACA established plans)^f	N/A	Insurance companies may continue to offer plans in the nongroup, small group, and large group markets. Plans must comply with applicable state and federal health insurance requirements, including ACA market reforms. ^g Premium tax credits or cost-sharing subsidies may not be used toward plans outside the exchanges. Individuals enrolled in plans offered through the nongroup, small group, or large group markets will have complied with ACA's individual mandate.
Grandfathered Plans^h	N/A	Existing health insurance coverage in which at least one person has been enrolled on or before March 23, 2010. Grandfathered plans are exempt from the majority of ACA's market reforms. Premium tax credits or cost-sharing subsidies may not be used toward grandfathered plans. Individuals enrolled in grandfathered plans will have complied with ACA's individual mandate.
Self-funded Plans	N/A	Health benefits are provided directly by the organization sponsoring coverage, so technically this is not insurance. Such organizations bear the risk; i.e., they are responsible for paying all covered medical expenses. Premium tax credits or cost-sharing subsidies may not be used toward self-funded plans. Individuals enrolled in self-funded plans will have complied with ACA's individual mandate. Self-funded plans are also referred to as self-insured plans.
Union Plansⁱ	N/A	Union plans are collectively bargained and maintained by one or more employers. Such plans are exclusively available to unionized employees and their dependents. Premium tax credits or cost-sharing subsidies may not be used toward union plans. Individuals enrolled in plans offered through unions will have complied with ACA's individual mandate.

Types of Health Plans	Inside ACA Exchanges	Outside ACA Exchanges
Retiree-only Plans	N/A	Health plans offered only to retirees of a given employer sponsoring such health benefits are exempt from federal health insurance requirements, including ACA. ⁱ Premium tax credits or cost-sharing subsidies may not be used toward retiree-only plans. Individuals enrolled in retiree-only plans offered through former employers will have complied with ACA's individual mandate.
Vision Plans, Ancillary Insurance Products, and Limited-benefit Plans	N/A ^k	Vision-only plans, ancillary insurance products, and limited-benefit plans are all allowed to be offered outside of exchanges. Premium tax credits or cost-sharing subsidies may not be used toward plans that provide only a single set of or limited benefits. Enrollment only in a plan that provides less than comprehensive benefits would not meet ACA's individual mandate.

Source: CRS analysis of ACA, other applicable federal requirements, and state health insurance standards.

Notes: The plan headers are not mutually exclusive. For example, a high-deductible health plan may be offered as a plan in the nongroup, small group, or large group market. The plans for which premium tax credits and cost-sharing subsidies may be used assume the individual/family meets all eligibility criteria (e.g., income requirement). The plans for which enrollment would satisfy the individual mandate assume the coverage has met all applicable federal and state health insurance requirements to be offered in the private market, whether inside or outside of exchanges. The plans for which sole enrollment would *not* satisfy the individual mandate assume such coverage has not been recognized by the Secretary of Health and Human Services as meeting the individual mandate requirements.

- a. A QHP is a new type of comprehensive health plan, established under ACA, that is subject to standards related to marketing, choice of providers, plan networks, essential benefits, cost-sharing limits, and other features, as specified under §§1301-1302 of ACA. For additional information about QHPs, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*.
- b. The Small Business Health Option Program (SHOP) exchange will help qualified small employers select one or more QHPs to offer to their employees. Employers will contribute to the employee's premium and plan holders will not be eligible for premium tax credits or cost-sharing subsidies.
- c. The precious metal designations refer to specific ACA standards related to actuarial value. Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. In other words, the higher the percentage, the lower the cost-sharing, on average. Each precious metal corresponds to a specific actuarial value: Bronze (actuarial value of 60%), Silver (70%), Gold (80%), and Platinum (90%).
- d. Prior to ACA, the term catastrophic was used generically to refer to high-deductible health plans (HDHPs). Under ACA, catastrophic has a specific meaning that distinguishes such a plan from other HDHPs.
- e. ACA mandates that most individuals have insurance coverage, but it provides a number of exemptions, one of them being for individuals experiencing a financial hardship.
- f. The private health insurance market is often described as containing three segments: the nongroup (individual), small group, and large group markets. The term "nongroup" refers to health insurance coverage offered to individuals (and potentially their dependents) that is not in connection with a group health plan (which is sponsored by an employer or employee organization, such as a union).
- g. While insurers that participate in exchanges and plans offered by such insurers are required to meet exchange-specific requirements, they also are subject to the same "market reforms" that apply to plans outside of exchanges. For additional information about these reforms, see CRS Report R42069, *Private*

- Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, and CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.
- h. See CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*.
 - i. ACA did not amend how union plans are negotiated, funded, or administered. However, certain ACA provisions may apply to the coverage offered through union plans. For example, union plans that are offered to active workers are subject to the requirement to extend dependent coverage to children under age 26. For a discussion regarding the applicability of ACA to union plans, see U.C. Berkeley Labor Center, *The Affordable Care Act: A Guide for Union Negotiators*, August 2012, <http://laborcenter.berkeley.edu/healthpolicy/acaguide12.pdf>.
 - j. This exemption pre-dates ACA. For a discussion about this exemption, see the Appendix of CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*.
 - k. All exchange plans, except for stand-alone dental plans, are required to offer EHBs. If exchange plans lack pediatric vision benefits, such plans must supplement those benefits through the addition of the entire set of pediatric vision benefits that are covered through either the largest vision plan under the Federal Employee Dental and Vision Insurance Program (FEDVIP), or the largest separate State Children's Health Insurance Plan (CHIP) in the state. For more information about CHIP, see CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*. Vision plans and ancillary insurance products (e.g., life or disability insurance) cannot be offered as stand-alone plans through an exchange, but an exchange may provide basic information about these types of plans on its website. For more information about exchanges and vision plans and other ancillary insurance products, see CMS's "Frequently Asked Questions on Reuse of Exchange for Ancillary Products," <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-2013.pdf>. It is unclear from this guidance whether "ancillary insurance products" could include limited-benefit plans as they are being defined in this report. Limited-benefit plans (e.g., plans that include benefits that treat only a single disease) cannot be offered through an exchange. Enrollment only in a plan that provides less than comprehensive benefits would not meet ACA's individual mandate.

ACA Market Reforms Applicable to Private Health Plans

ACA establishes federal requirements that apply to private health insurance. The reforms affect insurance offered to groups and individuals, impose requirements on sponsors of coverage (such as employers), and, collectively, establish a federal floor with respect to access to coverage, premiums, benefits, cost-sharing, and consumer protections. While some of these market reforms are new at the federal level, many of ACA's reforms have already been enacted in some states, with great variation in scope and specificity of those state requirements.¹⁰ Some of ACA's market reforms have already been implemented, while others become effective in 2014.

Given the breadth of types of health coverage, ACA market reforms may affect health plans differently. Some provisions will apply uniformly while others may be more specific to a type of plan. For instance, nearly all plans are required to extend dependent coverage to children under the age of 26. In contrast, several plan types are exempt from the requirement to cover essential health benefits: grandfathered plans, large group plans,¹¹ self-funded plans, retiree-only plans, and plans that provide limited benefits.

¹⁰ For more information about the market reforms, see CRS Reports CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, and CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

¹¹ However, states have the option to allow large groups to purchase insurance offered through exchanges. All exchange plans (with the exception of stand-alone dental plans) are required to offer EHBs.

Table 2 indicates the applicability of select ACA market reforms¹² to different types of health coverage; plan types are column headers, while reforms are row headers. The first four market reforms listed in the table became effective prior to 2014 (shaded rows); the remaining reforms will become effective in 2014. For table cells where a market reform applies to some but not all categories within a plan type, the exceptions are described in table notes. For example, the minimum medical loss ratio requirement applies to certain categories of grandfathered plans, but not all grandfathered plans. The category of grandfathered plans that is exempt from this requirement is described in a table note. Other exemptions are likewise indicated in table notes.

¹² The table considers most market reforms included in ACA. However, there are other federal and state requirements that may also apply to these various plans, including some preexisting requirements that are similar to ACA provisions. For example, ACA includes a guaranteed issue provision. Such a requirement existed, prior to ACA, at the federal level for certain types of plans and in certain states.

Table 2. Applicability of Selected ACA Market Reforms to Private Health Plan Types

ACA Market Reforms	Plans Offered Only Inside Exchanges	Plans Offered Both Inside and Outside Exchanges					Plans Offered Only Outside Exchanges					
	Multi-State Plans (MSPs)	Qualified Health Plans (QHPs)	Child-only Plans	Health Cooperatives	Catastrophic and other High Deductible Health Plans (HDHPs)	Stand-alone Dental Plans	Nongroup, Small Group, and Large Group Plans (non-ACA)	Grand-fathered Plans	Self-funded Plans	Union Plans	Retiree-only Plans	Vision Plans, Ancillary Insurance Products, and Limited-benefit Plans
Prohibition on Lifetime Dollar Limits	√	√	√	√	√	—	√	√	√	√	—	—
Coverage of Preventive Health Services with No Cost-Sharing	√	√	√	√	√	—	√ ^a	—	√ ^a	√ ^a	—	—
Extension of Dependent Coverage	√	√	√	√	√	—	√	√	√	√	—	—
Minimum Medical Loss Ratio (MLR)	√	√	√	√	√ ^b	—	√ ^c	√ ^c	—	√ ^c	—	—
Essential Health Benefits (EHBs)	√	√	√	√	√ ^d	Dental benefits only	√ ^e	—	—	√ ^e	—	—
Minimum Actuarial Value	√	√	√	√	√ ^d	—	√ ^e	—	—	√ ^e	—	—

ACA Market Reforms	Plans Offered Only Inside Exchanges	Plans Offered Both Inside and Outside Exchanges					Plans Offered Only Outside Exchanges					
	Multi-State Plans (MSPs)	Qualified Health Plans (QHPs)	Child-only Plans	Health Cooperatives	Catastrophic and other High Deductible Health Plans (HDHPs)	Stand-alone Dental Plans	Nongroup, Small Group, and Large Group Plans (non-ACA)	Grandfathered Plans	Self-funded Plans	Union Plans	Retiree-only Plans	Vision Plans, Ancillary Insurance Products, and Limited-benefit Plans
Prohibition on Annual Dollar Limits	√	√	√	√	√	—	√ ^f	√ ^g	√	√	—	—
Non-discrimination based on Health Status	√	√	√	√	√	—	√ ^a	—	√ ^a	√ ^a	—	—
Guaranteed Issue and Guaranteed Renewal	√	√	√	√	√ ^b	—	√ ^h	—	—	√ ^h	—	—
Coverage of Preexisting Health Conditions (Regardless of Age)	√	√	√	√	√	—	√ ^f	√ ^g	√	√	—	—
Rating Restrictions	√	√	√	√	√ ^d	—	√ ^e	—	—	√ ^e	—	—

Source: CRS analysis of ACA.

Notes: The plan headers are not mutually exclusive. For example, a high-deductible health plan may be offered as a plan in the nongroup, small group, or large group market. Shaded area indicates ACA market reforms with a pre-2014 effective date. Unshaded area indicates ACA market reforms with a 2014 effective date. For descriptions of these market reforms, see CRS Reports CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, and CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*.

- a. Grandfathered plans are exempt.
- b. Self-funded HDHPs are exempt.

- c. Self-funded plans are exempt.
- d. HDHPs offered in the large group market or that are self-funded are exempt.
- e. Large group plans, grandfathered plans, and self-funded plans are exempt.
- f. Grandfathered nongroup plans are exempt.
- g. Nongroup plans are exempt.
- h. Grandfathered plans and self-funded plans are exempt.

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